State of Wisconsin
Dept of Workforce Development
Equal Rights Division
Civil Rights Bureau

Family and Medical Leave Complaint

ERD Case # CR

For ERD Use Only

Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Provide all information requested. Type or print In black Ink

1. Complainant Information

First Name		
Middle Name or Initial		
Last Name		
Street Address		
City	State	Zip Code
Home Telephone Number **( )**- -		
Work Telephone Number **( )**- - Ext.		

2. Respondent Information

Name of the business you believe violated the law. Name only one Respondent per form. Do **not** name an individual person.		
Street Address		
City	State	Zip Code
Telephone Number **( )- -** Ext.		
County where the violation took place		

3. Employment Status

First date of employment with this employer (mm/dd/yyyy)
I have worked more than 52 continuous weeks for this employer at one or more of it's locations or departments ☐ Yes ☐ No
I have worked at least 1000 hours for this employer during the last 52 weeks ☐ Yes ☐ No
A total of at least 50 people work for this employer at all of it's locations ☐ Yes ☐ No

4. Previous Family and Medical Leave Use

I have used Family or Medical Leave during the current calendar year ☐Yes ☐ No If yes, how much leave did you take and for what reason
My employer has a poster displayed explaining my rights under the Wisconsin Family and Medical Leave Act ☐ Yes ☐ No

5. Present Leave Request. I have requested leave for the following reason (check appropriate answer)

☐ For the birth or adoption of my child (Family Leave)	
☐ To care for a seriously ill child, spouse, parent or parent-in law (Family Leave)	
Name of individual with serious health condition	Individual's relationship to you
Serious health condition description	

☐ For my own serious health condition (Medical Leave)
Serious health condition description
I requested Family Leave for the birth or adoption of my child or to care for a seriously ill family member ☐ Verbally ☐ In writing on

Name of individual from whom you requested family leave	Individual's Title

I requested medical leave for my own serious health condition ☐ Verbally ☐ In writing on

Name of individual from whom you requested family leave	Individual's Title

☐ I did not request Family or Medical Leave because I was unaware of my rights
Amount of leave requested
Dates expected to be off work

6. Denial of Leave

Date I received notice that my leave request was denied
Reason employer denied leave request
Date rights were violated
Reason I believe my rights under the Family and Medical Leave Act were violated

By my signature below, I, or my authorized representative, state that I have read and understand this complaint and swear that it is true to the best of my knowledge and belief.

Complaint or Complainants Representative Signature	Date Signed

The Department of Workforce Development is an equal opportunity service provider. If you need assistance to access services or material in an alternate format, please contact us.

EQUAL RIGHTS COMPLAINT PROCESS INFORMATION SHEET

Please complete and return this sheet with your completed complaint. This information is necessary to process your complaint effectively.

Complainant First Name	Complainant Middle Name or Initial	Complainant Last Name
Current Date	Complainant Date of Birth (requested for identification purposes) mm/dd/yyyy	

Contact Information (Important! The Complainant must notify the Equal Rights Division, if there is a change of address or telephone number. If we are unable to locate the Complainant, the complaint may be dismissed).

Is there a telephone number where the Complainant can be reached between 7:45 a.m. & 4:30 p.m.? ☐ Yes ☐ No	If yes, provide the area code and telephone number **( )**- -

Please provide the name, address, and telephone number of someone who does not reside with the Complainant but who will know where to reach the Complainant.

Contact Person Name		Relationship to the Complainant		
Street Address	City	State	Zip Code	Telephone Number **( )**- -

Employer Information

Approximate number of employees at all of the employer's work locations ☐ Less than 50 ☐ 50-100 ☐ 101-200 ☐ 201-500 ☐ More than 500	**Type of Business**
Does another company own the employer ☐ Yes ☐ No ☐ Not Sure	If yes, please provide the name of that company

Filing With other Agencies

Have you filed a complaint in this matter with any other agency ☐ Yes ☐ No	If yes, name of agency	Date filed with the other agency

Settlement Information

At this time, what is the Complainant seeking to settle the complaint

Complete this section if the Complainant was or still is employed by the employer

When was the Complainant hired	What was/is the job title	Is the Complainant still employed by the Respondent ☐ Yes ☐ No

Complete this section if the Complainant is no longer employed by the employer

How did the Complainant's employment end ☐ Discharged ☐ Quit ☐ Laid off ☐ Retired ☐ Other	Date Employment Ended	Pay Rate at End	Hours per Week
If the Complainant was not promoted, what was the title of the position applied for		Rate of Pay	Hours per Week

Statistical Information

Complainant Sex:
☐ Male ☐ Female

Complainant Race (check appropriate box or boxes):
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Black or African American
☐ Asian ☐ White ☐ Other

Mail your completed and signed complaint form to one of the following addresses:

EQUAL RIGHTS DIVISION
201 E WASHINGTON AVE ROOM A300
PO BOX 8928
MADISON WI 53708

Telephone: 608-266-6860
FAX: 608-267-4592
TTY: 608-264-8752

EQUAL RIGHTS DIVISION
819 N 6TH ST
ROOM 255
MILWAUKEE WI 53203

Telephone: 414-227-4384
FAX: 414-227-4084
TTY: 414-227-4081